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Vol. CVII OCTOBER, 1913 Number 10

NASHVILLE JOURNAL

OF

MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor and Proprietor
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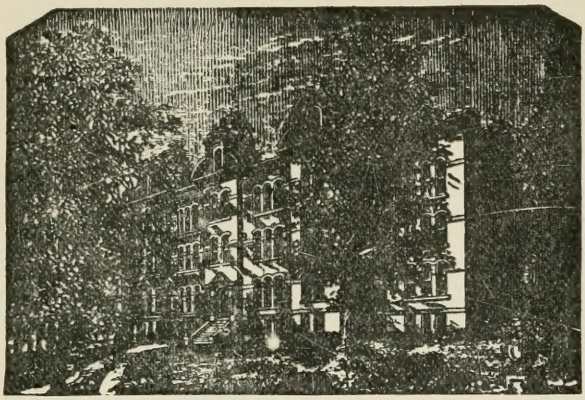

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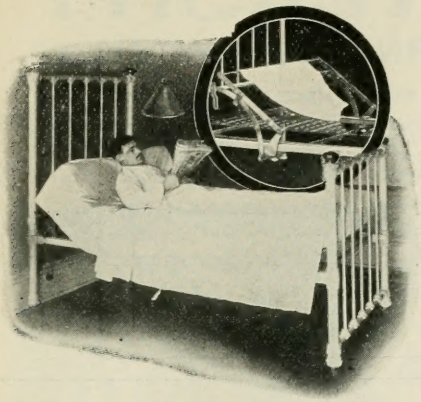

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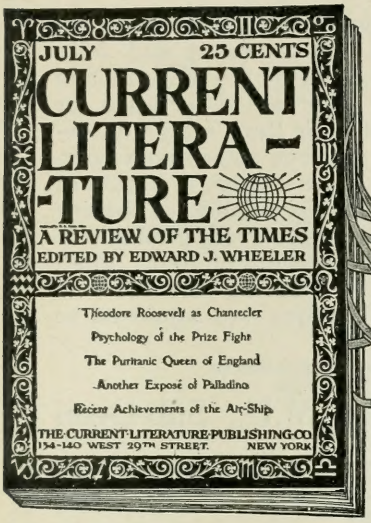
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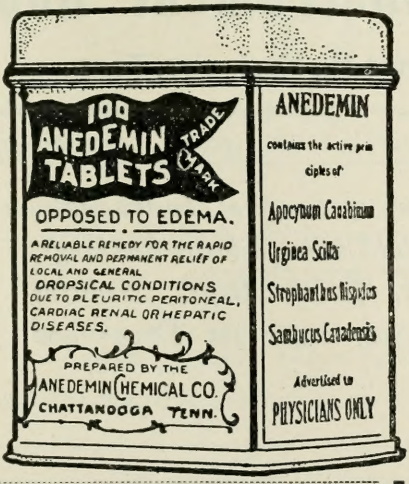
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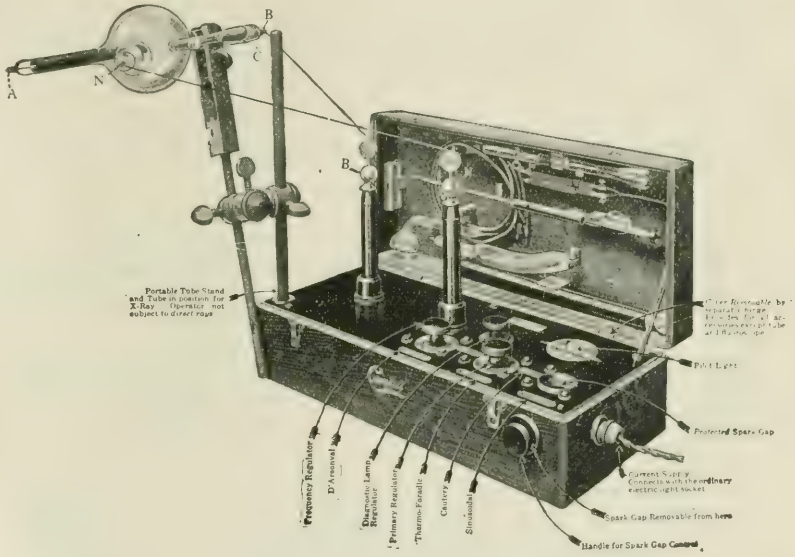

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NASHVILLE JOURNAL
—OF—
MEDICINE AND SURGERY

CHARLES S. BRIGGS, A. M., M. D., Editor

VOL. CVII. OCTOBER, 1913. No. 10

Selected Articles

SUDDEN DEATH DURING CONFINEMENT.

(Translated from an extract in the *Journal de Medicine et de Chirurgie,* by W. T. Briggs, M.D., Nashville, Tenn.)

Dr. Rudaux, hospital obstetrician in *La Clinique,* writes of conditions in which sudden death occurs during or shortly after delivery. In labor proper, rupture of the uterus, hemorrhage, organic heart disease, embolism or cerebral hemorrhage, at times even shock, are the conditions which bring about sudden death. During labor itself, heart diseases, hemorrhage, at times vaginal and uterine injections can be the cause of sudden death. But we here claim, according to the researches of Dr. Rudaux, that sudden death may occur several hours after delivery. From a clinical point of view the several hours which follow delivery properly so called belong still to the period of accouchment. The patient feels good, she is enjoying a well deserved rest, yet her system feels the effects of the severe ordeal through which she has just passed. Her circulatory system has to adapt itself to certain radical and rapid changes that follow the expulsion of the child and which still obtain after the expulsion of the afterbirth. The uterus should contract in order to close the mouths of all the blood vessels which otherwise would empty themselves into the cavity of the womb. On this account the attending obstetrician should

constantly during this period of confinement give close attention both to the necessary contraction of the womb and to the pulse phases.

Subjects of heart disease are threatened with sudden death as the result of asthmatic crises, of pulmonary œdema or even an attack of heart failure or loss of cardiac tone, for the arterial hypertension incident to the condition persists a certain time after delivery.

The uterus, for the same reasons as apply to the foregoing conditions, that is exaggerated fatigue, excessive distension, insertion of the placenta to the inferior segment of the womb, too rapid delivery, etc., may be affected with inertia and as a result there occurs a dangerous degree of post partum hemorrhage. This inertia and its result—hemorrhage—can be brought about by an incomplete delivery, by the retention of clots in the cavity of the uterus or by the presence of inflammation in the body of the uterus. The gravity of these hemorrhages is in proportion to the degree of care taken by the accoucheur and frequently occur when the attendant in the case leaves the bedside of the patient too soon. It is during this period, just after delivery, that occurs that form of anemia graphically described by Tarnier and Burdin: "After a considerable loss of blood, the patient seems to have recovered, and she has responded thoroughly to stimulants, she is regarded as out of danger, when in two or three hours, possibly twenty-four hours after the accident, she is found dead in bed. This is a sudden death which nothing could have prevented."

After a long and painful labor, after a difficult instrumental delivery, the woman may die without such appreciable causes as hemorrhage or rupture of the uterus or inversion. She may die of shock. Death is due to a veritable nervous exhaustion. "In the economy there is only a given amount of nerve strength and resisting power" (Cruveilhier).

Moral suffering can act in the same way. Added to physical pain, it can lead up to fatal syncope. It is in this way that medico-legal experts explain certain fatal results occuring during clan-

destine accouchements, even when there is no evidence of hemorrhage or other threatening accidents.

Pulmonary embolus and the entrance of air into the veins should be considered as conditions likely to obtain in the period immediately following delivery. For a long time these two accidents have held first place in the classification of the causes of sudden death after delivery. Pulmonary embolism is fatal only when the trunk of the pulmonary artery or one of its principal branches of bifurcation is obstructed. The clot most frequently escapes from a uterine sinus as the result of a violent movement or sudden exertion on the part of the patient. According to Brouardel, the clot (or embolus) may escape from a thrombus of the lower extremities or from the vena cava which he considers as possible before confinement or even from a thrombosis of the peri-uterine veins.

Carlo reports in a paper a case of Charles of Brussels in which sudden death supervened the day of delivery. It happened in a woman in whom there was a vicious attachment of the placenta causing hemorrhage during the period of dilatation. For the repression of the hemorrhage recourse was unfortunately had to a septic tampon.

The entrance of air into the veins was for a long time looked upon as the principal factor of sudden deaths following labor. A great deal has been written on this subject since 1818. But the theory has never been generally agreed upon. The gases which have been formed in the vessels may have been the result of cadaveric putrefaction or to the entrance into the vessels of such gases at the very moment of death.

Sudden death, then, may occur during delivery or in the period immediately following that process. When it occurs as a sequel to delivery it can be brought about by the same causes that act in delivery, that is, as the result of organic heart trouble or of syncope. But the principal cause of sudden death in the immediate post partum period is infection which gains entrance at the time of delivery and more especially the infection which has its origin in the venous system. When we look over obstetric literature bearing upon the subject we find that embolism is the most

common cause of sudden death in the period immediately following parturition. The embolus may occur in a woman who has a well marked phlegmasia alba dolens or a latent phlebitis, an affection which has been ably described by Dr. Brun and Madame Liehrman. In the two cases the picture is the same. A woman with phlebitis makes an effort to raise up or sit up in bed or even it may happen with a patient presenting no sign of inflammation of a vein, who gets up for the first time in order to leave the hospital sooner than she should, she cries out, becomes pale and falls back dead.

Sometimes the scene is less rapid and time is given to assist the organism in the asphyxia caused by the arrest of a clot in one of the branches of division of the pulmonary artery. Whether as the result of sudden movement or more rarely without apparent cause, the patient feels all at once an extreme sense of suffocation, she has the feeling of a tight constriction of the chest, she experiences a sensation of being smothered, she fights for her breath, the mouth is widely open, the nostrils are distended, the face is cyanosed, the eyeballs protruding, the pulse at first rapid, becomes very feeble at the same time that the extremities get cold and in the space of several agonizing minutes, sometimes even in half an hour, the patient succumbs. It is more frequently on the fourteenth or the twenty-fourth day, sometimes sooner, towards the tenth day, sometimes later, a month after delivery, that this accident occurs.

In the course of infection of puerperal origin, sudden death may supervene as the result of intense general septicæmia, simply the puerperal toxæmia of Hervient, either localized in the serous envelopes of the heart or of the lung or in the musculature of the heart. As in all infections the myocardium may be weakened all at once by the action of toxines upon the tissue. This action upon the myorcardium is the same as that produced by the diphtheritic toxine. So sudden death from myocarditis may supervene in the course of manifestations of infection or in full convalescence.

THE MANAGEMENT OF HIGH BLOOD PRESSURE.

By George Morris Piersol, M.D.,
Associate in Medicine in the University of Pennsylvania.

At the outset it must be clearly borne in mind that persistent vascular hypertension is not a disease *per se,* but is merely a symptom of some underlying morbid process. When, through the introduction of clinical sphygmomanometers, high pressure first came to be generally recognized there was a decided disposition to focus the attention too much on this symptom and, regardless of its significance, to attempt to combat it by vigorous measures. Happily this tendency has gradually yielded to a more rational conception of the process, and we are learning to appreciate the importance of the teachings of Loeb,[1] Janeway,[2] and others, namely, that high blood-pressure is primarily compensatory. In the two most important conditions associated with hypertension, chronic nephritis and arteriosclerosis, it has been shown that in the former the high blood-pressure is essential in order to maintain adequate elimination through the damaged kidneys, and in arteriosclerosis the elevated pressure helps increase the circulation in organs whose nutrition is impaired because of their diminished blood supply. Nature, nevertheless, sometimes overdoes in her efforts at compensation. Just as fever, useful as it is, may become so excessive as to endanger the organism; so with blood-pressure, the elevation may reach a point that makes efforts directed toward its reduction justifiable. When such is the case, we should not be content with the mere attempt to control this one manifestation of disease, but should seek for its underlying cause and so far as possible remove it.

When we consider that persistent high blood pressure results for the most part from lesions in the kidneys or blood vessels, it is evident that its treatment falls under two heads: (1) its prophylaxis, and (2) its management when once developed. Of these the former is by far the more important and hopeful, since in

arteriosclerosis and nephritis it is more than ever true that "an ounce of prevention is worth a pound of cure."

Prophylaxis of High Blood-pressure.—The first step toward the prevention of well-developed hypertension is the early recognition of the conditions which produce it. To this end we possess a method of clinical examination which is so readily carried out that it lies within reach of every practitioner, namely, the routine estimation of the blood pressure, both systolic and diastolic. Were this procedure performed carefully and systematically as part of the routine examination of all patients, regardless of the character of their complaints, nephritis would be recognized in its early stages before grave secondary changes occur in the circulatory system, and developing arteriosclerosis would be detected at a time when elevation of pressure is only moderate and due to vessel spasm, before anatomical changes in the vessel walls render therapy of little avail. The importance of routine blood-pressure determination, therefore, as a prophylactic measure, can not be too strongly emphasized.

When an individual approaching or past middle life shows early evidence of arteriosclerosis, much can be done at least to prevent a further advance of the condition. If by good fortune organic changes in the vessels have not yet occurred, and vessel spasm alone is present, the outlook is encouraging, provided adequate treatment is conscientiously carried out.

Such treatment involves first of all proper attention to the patient's general hygiene and mode of life. Physical over-exertion as well as mental strain and worries must be avoided; the patient should take a proper amount of recreation and rest—the latter, particularly, must be insisted upon—and recreations must be devised which afford the patient a maximum amount of fresh air and moderate exercise without causing any over-exertion or fatigue. Proper elimination should be insured by having the patient take several times a week hot-air or electric baths or hot packs, and the bowels should be kept freely moved without causing actual purging.

Of equal importance in these cases is the diet. Alcohol, coffee, and all irritating food and drink should be avoided, and the quan-

tity rather than the quality of the diet should be restricted. The intake of nitrogenous foods should be reduced and the patient given an otherwise wholesome, sufficiently mixed diet. Water should be taken freely, but only in moderation with the meals.

If intestinal toxemia is suspected or proved, high colonic irrigations two or three times a week are of value, and there are some who have claimed good results from the use of the Bulgarian lactic acid bacillus. As a result of the teachings of Lane, at present a popular intestinal antiseptic and laxative is found in paraffin oil administered in cold water after each meal in doses of one-half ounce.

All sources of chronic infection, as sinusitis, pyorrhea alveolaris, chronic prostatitis, or pelvic inflammatory disease, etc., must be sought for and removed. Many cases occur in which arteriosclerosis develops as the result of gradual intoxication from a focus of chronic infection. I can recall two cases of sclerosis in which chronic cholecystitis played an important role in the etiology. I have under my care at present a woman in whom a gradually developing arteriosclerosis and nephritis are undoubtedly the result of a chronic pelvic infection. The benefit which occurs following the removal of such foci of intoxication was shown by the case of a middle-aged man, previously healthy, who gradually developed a systolic blood pressure of 160 without apparent cause. Careful search finally revealed the existence of a chronic low-grade sinusitis. After this condition was removed his blood pressure soon returned to normal, where, so far as I know, it has remained.

An additional prophylactic factor of importance in arteriosclerosis is the education of the patients themselves to the necessity of easing up upon the activities of life after fifty is reached; to the advantage of lessening the quantity of food taken as they grow older, and the avoidance of alcohol, tobacco, etc.; and finally, to the wisdom, as a precautionary measure, of submitting themselves for physical examinations and blood pressure determinations at stated intervals.

The prevention of nephritis does not differ materially from that above outlined, since the causes of chronic nephritis are not

dissimilar from those of arteriosclerosis. In addition, however, the frequency with which nephritis follows infections, even of minor grade, must not be lost sight of, and it is incumbent upon the general practitioner to see that all cases of acute infections, however mild, are kept in bed, their diet restricted, and their elimination adequately maintained; that every effort is made to prevent the occurrence of a nephritis; and that before these patients are finally discharged it is definitely determined that their urine is normal and that no abnormal alteration has occurred in their blood pressure. Were these measures conscientiously carried out, there is no doubt but that many cases of chronic Bright's disease and arteriosclerosis might be averted.

The Treatment of Developed Hypertension.—The management of high blood pressure, when its existence depends upon some well-defined, irremediable anatomical change in the organism, is both difficult and unsatisfactory. Whether the dominant lesion is renal or vascular, the underlying cause is usually toxic and the hypertension is in part compensatory, hence our chief efforts must again be to aid Nature by increasing the elimination and lessening the production of the toxic agent. The measures most useful for this purpose are comprised under the following:

Rest.—No more efficient method exists of lowering blood pressure and giving the body an opportunity to readjust disturbed functions than prolonged rest in bed. Even when complete rest is not desirable the patient's daily life should be regulated so as to allow for periods of rest and quiet during the day and at least eight hours in bed every night.

A principle of fundamental importance in the management of hypertension is the prevention of all forms of sudden strain and the avoidance of everything which tends to produce bodily or mental fatigue.

Dietetic.—As in the prophylactic treatment, the diet in cases of high blood pressure should be limited in quantity particularly, especially as overeating has frequently been the fundamental error in many of these cases. The nitrogenous intake should be restricted and all stimulants, especially alcohol, coffee, and tobacco, must be avoided. The patients should be instructed to eat

regularly, slowly, and to chew well; to rest one-half hour after meals, and to take their heartiest meal at midday; to limit the amount of fluid taken with each meal to six ounces, and to drink water between meals.

Elimination.—In addition to the kidneys, the chief avenues through which elimination may be obtained are the bowels and the skin. Violent cathartics are contraindicated, but several free bowel movements should be obtained daily by the use of such laxatives as senna, rhubarb, cascara, and milk of magnesia. The addition to the diet of stewed fruit is of great help in this respect. In some cases the salines in moderate doses taken in plenty of water before breakfast seem most efficient. A good practice is in addition to have the patient take a dose of blue mass (gr. v-x), followed by a saline every two or three weeks.

Various forms of sweating have been devised in order to increase the activity of the skin. The excessive sweating sometimes advocated is frequently harmful to many of these cases of high pressure, and the steam room of the Turkish bath is decidedly depressing and dangerous. Short electric-light baths, carefully given, or hot packs, or even simple hot baths are usually sufficiently vigorous measures. In beginning treatment it is well to have the patient take such a bath every day for a week, then the next week every other day, and finally two or three times a week as a routine procedure. The value of these baths is not that they cause any permanent or marked lowering of the pressure, for it has been shown that the lowering is only moderate while the baths are being taken and that the blood pressure soon returns, but that they cause increased elimination by inducing cutaneous hyperemia, which in turn lessens the congestion of the splanchnic and other great visceral vascular areas.

The slight blood pressure lowering effect of vapor baths was clearly shown in a patient under my care at the University Hospital. This patient, a man aged sixty-two years, who had a chronic interstitial nephritis with a systolic blood pressure which ranged for months between 220 and 260, became uremic and was given frequent vapor baths. A series of blood-pressure readings made before and after these baths showed that one-half hour

after a bath the systolic blood pressure only fell from 2 to 12 mm., and the average decrease in the diastolic pressure was but 5 mm.

A procedure of undoubted value in the management of certain cases of high tension is venous section. This method does seem to cause at least a temporary lowering of pressure, and may be practiced with safety provided the amount of blood withdrawn is controlled by frequent blood pressure readings. Twelve to twenty ounces can usually be removed with impunity. Miller[3] found the blood pressure was lowered only for a short time, and in cases of uremia that were bled, the pressure was often not lowered at all. Another uremia patient, which I observed at the University Hospital, following a convulsion, had a systolic blood pressure of 275 and a diastolic pressure of 170. Eighteen ounces of blood were withdrawn thirty minutes after the convulsion, and immediately after the bleeding his blood pressure was, systolic 230, diastolic 170. Within five days, however, in spite of active eliminative measures, his blood pressure had returned to its former level. The good that results in these cases from bleeding may be due to the withdrawal of a certain amount of toxic material.

Drugs.—Finally we may turn to a consideration of drugs in the treatment of persistent hypertension. The promiscuous use of the nitrites whenever high blood pressure is encountered, regardless of its significance, must be looked upon as an ill-advised therapeutic habit into which too many of us have fallen. From the careful work that has of late been done on this subject it seems well established that not only do the nitrites fail to do any good, but in a number of cases, if we accept the compensatory conception of hypertension, they are capable of positive harm.

That nitrites lower blood pressure by dilating the vessels is undoubted, but that this lowering is decidedly fugacious is equally certain. It has also been shown that when nitrites are used over any length of time in ordinary doses their vasodilator effect becomes nil. In a series of careful observations Miller[4] showed that when either nitroglycerin, erythrol tetranitrate, or sodium nitrite was given, a fall of blood pressure strikingly similar in each case resulted in two to four minutes, but that in each case this fall

was but temporary and that in two hours the blood pressure had regained its previous level. From this it is evident that these vasodilators find their chief use when it is necessary to combat some sudden condition of spasm such as angina pectoris or nocturnal dyspnea, but that they are inefficient as routine means of treatment.

In a series of fifty cases in which the average systolic pressure was 200 mm. recently analyzed by me, nitroglycerin was employed at some time in the treatment of twenty-seven cases. Of this number it seemed to have a beneficial effect on the blood pressure in but three; in six its advantage or disadvantage could not be determined; while in the remaining nineteen cases it had apparently no noteworthy effect.

In contradistinction to vasodilators and paradoxical as it may seem, distinct benefit seems to have resulted from the use of digitalis in some cases. Cushny[5] has amply demonstrated that except in conditions of low tension and circulatory failure digitalis does not raise blood pressure. This drug may, therefore, be employed in small doses with safety in these cases. It does good chiefly in those patients in whom cardiac weakness is developing, and often is wonderfully efficient in relieving the distressing dyspnea and vertigo.

In my series eight cases were markedly helped symptomatically by the use of digitalis, and one-half of these patients were showing some indicatiion of decompensation.

Cardiac depressants sometimes are effective in relieving certain of the most distressing symptoms of hypertension, such as the headaches, throbbing, and vertigo. In one patient with a blood pressure of 220, after all else had failed, aconitine in doses of gr. 1-240 every four hours relieved a persistent headache. Another patient who for years has had a tremendously high blood pressure, obtains some relief from her headache by taking the tincture of aconite in doses of fifteen to twenty-five drops four times a day. The slight effect which these enormous doses have on her blood pressure and her general condition makes one agree with Rudolf[6] and question the efficacy of the ordinary doses of this preparation. She recently took 100 drops a day of the U. S.

P. tincture of aconite continuously for five weeks, and before, during, and after this period her blood pressure remained fairly constant—systolic 220 to 230; diastolic 130 to 150. Like aconite, veratrum viride may sometimes prove useful in lessening blood pressure. In one of the uremic patients above referred to the fluid extract of veratrum viride, given in doses of 3 minims every four hours for three days, reduced the systolic blood pressure only 6 mm., but the diastolic fell 15 mm.

The iodides have always enjoyed a reputation in the treatment of hypertension. Their exact mode of action is not clear and their use is largely empirical. Thamias,[7] however, believes that when arteriosclerosis is of syphilitic origin potassium iodide does good. Perhaps the secret of the value of the iodides will be revealed when Wassermann reactions are done more frequently in these cases of high arterial tension. In view of the fact that antisyphilitic treatment does seem to help some cases in which lues is the etiologic factor, the Wassermann reaction assumes an importance from the standpoint of both prognosis and treatment.

All things considered, it must be admitted that in well-developed hypertension dependent upon organic changes, be it of vascular or renal origin, efforts to lower it are of but little avail. In the fifty cases I have analyzed, in only fourteen can it be said that any of the therapeutic measures employed had much effect on lowering the blood pressure. On the other hand, there is little doubt but that the general hygienic treatment of these patients, relieving them from physical exertion and mental anxiety, regulating their digestions, and promoting their elimination, were most important factors in adding to their comfort and prolonging their lives, even though the hypertension itself was unaffected.

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SURGICAL

The Treatment of Lues.

Cole (*Cleveland Journal,* April, 1913,) after reviewing the modern concept of syphiliis and the application of drugs for its relief states that the ideal treatment, and the one being practically used at several of the best known European clinics, is as follows: The patient receives an intravenous injection of neosalvarsan, the dose depending on the case and on circumstances. At the same time or even a little before, an intramuscular injection of oleum cinereum, 0.125 cc., is given and repeated in three days if well borne. The arsenic preparation is likewise repeated after eight days, though in a larger dose, and twice again in the space of two weeks; while for four consecutive weeks the patient receives an intramuscular injection of 0.25 cc. oleum cinereum, During all this time an injection of mercury biniodide of one-fourth of a grain (0.01 gramme) might be given the middle of each week, and in the respite of five or six weeks in the oleum cinereum injections it could be used once or twice a week. Then another series of five injections of eleum cinereum of 0.25 cc. each is made, one each week. One course of treatment is then finished and the patient is allowed a rest of a month, when a Wassermann reaction is tried. If it be negative he is allowed to wait another month, when it is repeated. If it still be negative, the patient is, notwithstanding, given an intravenous injection of neosalvarsan and told to come back in two months for another blood examination. If it be still negative the question then arises: Is this patient cured, or not? We are still unable to settle this question definitely, and the writer suggests that at any rate another course of treatment should be given. Then if the blood still shows nothing, probably the patient is cured, though we must yet plead

partial ignorance, and it would be well to examine the blood every six months for a year or so. The present attitude in Europe is to inject approximately 2 grammes (30 grainns) of metallic mercury into the patient's system in the first year's treatment, and, depending on the case, if required, 1 gramme (15 grains) in the next two years. No luetic should be allowed to marry before he has had at least one year of the most intensive treatment and before his Wassermann reaction has been negative for at least two years. Marie Kauffmann-Wolff in her records of forty-five marriages, puts the patients in three classes, viz.: (1) wives of luetic husbands, the latter having been syphilitic before marriage or having contracted the disease extramatrimonially after marriage; (2) wives who have several times aborted or who have been the mothers of luetic children; (3) cases which belong to the type of "syphilic hereditaria." In forty-five cases so married, thirty are still living. Twice as many men as women are dead, and among the men diseases of the circulatory organs were the cause of death in one-half of them. Two of them had tabes, and two, still living, are suspicious of tabes. The greatest number of deaths were between the ages of forty and fifty. Of thirty still living seventeen show signs of lues, thirteen not. In one of the cases the wife was infected seven years after the husband had contracted lues. Of eighty-one pregnancies from the marriage there have been twenty abortions, three early births, five still-births, and twenty deaths in early childhood up to two and one-half years. Nine of the marriages have been childless—*i.e.*, five of them have been sterile, and in the other four there have been only abortions.

Syphilis is yearly sending thousands of our citizens to asylums and passing over stigmata to hundreds and hundreds of our children.—*The Therapeutic Gazette.*

Treatment of Tetanus.

McClintock and Hutchings believe that the following conclusions are warranted by their experiments: Amputation after the appearance of symptoms is of no value. The toxin appearing in

the blood stream is selflimited even in the fatal cases. There is little if any value in the phenol treatment of the disease. If there is any gain, the authors believe it is probably due to the sedative action of the drug and not to any direct action on the disease process, and that this result may be obtained with greater certainty by other drugs. The magnesium sulphate as used in their experiments subcutaneously was of no value. Antitetanic serum alone has a definite, although usually insufficient, curative effect. From the observation of a large number of animals and quite a number of human beings dying of tetanus, the authors thought that the exhaustion due to the muscular contractions is a large factor in producing fatal results. For this reason much of their work has been given to the attempt to hold these convulsions in check. The presence of a large amount of toxin in the blood several days (in sheep it can be demonstrated four days) before the onset of clinical symptoms makes it imperative that a method be devised for easily determining this. With such a method it is quite probable that a large proportion of tetanus cases could be saved. At present the best that can be done in the treatment of tetanus is to neutralize the toxin with repeated doses of serum while controlling the muscular spasm with some drug. —*The Journal of the American Med. Asso.*

Treatment of Fracture of the Neck of the Femur in the Aged.

The three essentials in the treatment of fracture of the neck of the femur in the aged are: (1) To keep the patient alive. (2) To obtain union of the fracture. (3) To secure as useful a limb as possible.

I am assuming that a correct diagnosis has been made by means of the clinical, X-ray examination under narcosis, etc. The first thing to do is to make the patient comfortable while confined to bed. Shock should be treated with stimulants and anodynes and the limb supported by sandbags or a simple splint. Special attention should be paid to the diet and the bowels and the urine carefully watched. A skilled nurse should be employed, who

knows not only how to care for, but also to entertain, the patient. The pulse and respiration should be regularly taken and all pressure spots and bed sores should at once receive the proper attention. Whether the fracture is within or without the capsule of the joint is of no great importance; but whether it is impacted or unimpacted is of great moment, because impacted fractures unite very readily, while the unimpacted often remain ununited and may require operative intervention.

The rational treatment is to place the leg in as natural a position in extension as possible. With the knee flexed with a pulley, strips of adhesive plaster should be applied to the leg and thigh as high up as the perineum and held in position by a gauze roller bandage. A weight of about 5 pounds should be attached to the extension strips while the leg is gently rotated and carefully placed in the normal position. The foot of the bed should be elevated about 6 inches to secure counter-extension. Sandbags should be placed on either side of the leg and thigh to afford support and give security. This treatment will not be applicable to all cases, since some require some form of fixation, of which the Thomas hip splint is another dressing that can be recommended. Sands advised a plaster-of-Paris spica bandage which extends from the nipple to the toes, and this has the advantage of securing perfect immobilization and constant traction, which can not be accomplished with a weight and pulley. However, one of our main objects should be to get the patient out of bed at the earliest possible moment, for the great danger in this class of cases is the occurrence of complications, such as hypostatic pneumonia, embolus, etc. In order to prevent these, either the plaster-of-Paris spica bandage should be applied or Hodge's suspension splint used as soon as feasible.

Up to the present time it is very evident that perfection has not been achieved in the treatment of this class of fractures, and in view of the great diversity of opinion which exists I am inclined to believe that the best method is the one that the individual knows best how to use, for the main object, after all, is to secure for the patient the most satisfactory functional result that can be obtained.—*International Journal of Surgery.*

Postanaesthetic Administration of Glucose.

Anæsthesia causes a sudden drain in the reserve supply of glycogen in the system. If the patient be not suitably fed, he begins to live at the expense of reserve fats, and, to some extent, proteins. These are imperfectly oxidized, and the intermediate products resulting from incomplete oxidation are toxic. The liver, upon which develops the task of neutralizing these toxic substances, is in a state of general functional inferiority owing to the lack of glycogen. From this the authors conclude that in order to combat postanæsthetic intoxications, carbohydrates must be supplied to the organism, both for prophylactic and curative purposes. Glucose (grape sugar) which is directly absorbable, is the food of choice for operated individuals. In order to facilitate its ingestion in sufficient amount, the following combination is prescribed by the authors:

℞ Glucose (150 Gm.).
Tincture of nux vomica, *m* viij (0.5 Gm.).
Tincture of cinnamon, *m* L (3 Gm.).
Water, enough to make ℥x (300 c.c.).
M.

This is to be taken in dessertspoonful doses every half hour. Vomiting is not only induced, but is arrested, by this solution. Where toxic disturbances have already appeared, glucose should be given freely by all routes: orally, rectally and even intravenously. Alkalies should also be administered, in conformity with the prevailing practice in diabetic coma.—*Medical Review of Reviews.*

Postoperative Pain.

The other day I had a tooth extracted. It was broken off and for ten minutes the operator hunted for the root, unsuccessfully. The gas anæsthesia endured about 50 seconds, so that I suffered acutely for over nine minutes. I reached my home, enduring agonies; every tooth in both jaws aching and exquisitely tender.

I consulted the dentist, who assured me the pain was from the operative injury.

That gave me the clue—one of the advantages claimed for H-M-C anæsthesia is the abolition or rather prevention of post-operative pain—and I am a firm believer in preventive medicine. If this remedy prevents such pain it also relieves it, so I took hypodermatically a half tablet containing morphine, grain 1-8, hyosine, grain 1-200, and cactoid, grain 1-128.

In a few minutes the pain seemed bearable; in twenty minutes it was fairly controlled. I slept well that night. Next day the face was swollen, but the pain presented only in occasional twinges

Judging from the reports of correspondents I had learned to look on this combination as the most powerful means at our disposal for the severer forms of pain; but this was my first personal experience with it.

In view of the atrocious character of the pain I am amazed at the speedy and permanent relief afforded by this minute dose. I had sometimes taken a dose of morphine alone to break up a cold, with good effect indeed, but a miserable headache next morning that always made me regret I had not let the cold run its course. This time there was no unpleasant symptoms following, not even constipation.—*Texas Medical Journal.*

Abolishment of Postoperative Pains With Nerve Block a Distance.

Leigh Watson, of Oklahoma City, believes the abolishment of pain after operation is most important. He uses a simple and efficient nerve block a distance (*Annals of Surgery*, May, 1913). Before beginning the operation, he generally uses weak cocaine or preferably novocain, ¼ per cent solution with adrenalin, and, whenever possible, both begins and finishes the operation under local anæsthesia. When analgesia is complete, he uses urea and quinine, which provides a complete nerve block. He finds that this combination gives an analgesia which continues from three to seven days. By the time the nerve block a distance has lost its

effect, healing has progressed sufficiently to make further anæsthesia unnecessary. With a comfortable and painless convalescence, it is reasonable to presume that as it becomes generally known that the post-operative pain can be elimiinated, surgery will lose much of its dread and perhaps operations will become more popular.—*The Lancet-Clinic.*

The Identity of the Cause of Aseptic Wound Fever and So-Called Post-Operative Hyperthyroidism and their Prevention.

As any form of force is converted into heat, the result of a psychic or mechanic stimulus reaching the brain should result in the production of heat. Operations performed under the principle and technique of anoci-association, showed a changed post-operative temperature and pulse curve. Blocking the wound with quinine and urea hydrochlorid, eliminated the post-operative phenomena of temperature and pulse. (Crile, *Ann. of Surg.*, May, 1913.) As reasons have been given for considering Graves' disease a disarrangement of the general motor mechanism lowering the threshold of the brain to both traumatic and psychic stimuli, it can be seen that the brain in a case of Graves' disease is driven harder by a given stimulus, than is the normal brain. A greater change in the pulse rate and temperature is the result. As morphia raises the threshold to stimuli, i. e., it makes it more difficult for stimuli to reach and act on the brain cells, the effect of that drug upon the pulse and temperature is explained. It explains why a case of Graves' disease under excitement without operation, shows the same phenomena as a case operated upon without anoci; and finally explains why a case operated upon under anoci, lacks these phenomena.

If at the time of operation, the patient receives such powerful psychic excitation that he tends, later, to recall the event, each time the original harmful stimuli of the operation are recalled through associative memory, there results a driving of the motor mechanism. Operating under anoci, prevents the impression

upon the brain. Therefore there can be no destructive recapitulation, *noannoci-associations*, consequently no retardation to normal convalescence. Thus there is a general principle underlying both postoperative hyperthyroidism, the latter being a pathologic, a magnified postoperative wound fever.—*Med. Review of Reviews.*

Thyrotomy for Cancer of the Larynx, With Report of Eleven Cases.

Dr. D. Crosby Greene, Boston: In a paper presented to this association in 1906 we reported the results of an investigation of the lymphatic drainage of the larynx by means of submucous injections of methylene blue and mercury. The results obtained are confirmatory of those reported by others in showing that the network of lymphatic vessels which extends beneath the mucous membrane throughout the interior of the larynx is richer in the number and size of the vessels in the supraglottic region, relatively poorer in the subglottic portion, while on the vocal chords the vessels are very small and widely separated. These anatomic facts account for the slow growth and late development of the disease in the cervical lympth nodes in cases of epithelioma of the chords, and furnish an argument for the possibility of cure in early cases by the operation of thyrotomy and excision of the growth with a wide margin of healthy tissue. This is supported by the result of the operation in the hands of numerous operators, both in this country and abroad, so that at the present time it is almost universally recognized as the proper procedure for the treatment of early intrinsic cancer of the larynx. Certain details of the technic have an important bearing on the immediate and after results of the operation. The steps of the operation are: 1. Ether by inhalation, preceded an hour before by one-fourth grain of morphine and 1-150 grain of atropin. 2. With the head slightly extended, a median incision is made, extending from the lower border of the hyoid bone to the lower border of the cricoid cartilage. This incision is carried down through the prethyroid muscles until the thyroid and cricoid cartilages and cricothyroid mem-

brane have been definitely exposed. 3. A one per cent, solution of cocain is injected through the cricothyroid membrane into the cavity of the larynx. 4. The patient is now placed in the Trendelenberg position and a thick pad placed under the shoulders to bring the larynx into prominence. 5. The cricothyroid membrane is next incised in the median line, and through this incision a swab of 10 per cent solution of cocain is introduced and applied to the laryngeal mucous membrane. 6. The thyroid cartilage, after a pause of five minutes, is divided from below upwards. In young subjects this may be done with a knife, but in the majority of cases where the cartilage has become ossified it is best to use strong curved scissors with dull points. 7. The thyroid wings are now widely retraced and an examination of the growth made under good illumination. 8. Beginning at the free margin of the thyroid cartilege, on the affected side in front of the growth, the internal perichondrium is elevated from off the cartilage with a sharp elevator from before backwards to a line well behind the limits of the growth, as well as above and below it. All the soft structures are thus freed from the underlying cartilage. 9. Parallel horizontal incisions are now made with scissors above and below the growth. These incisions are carried about one-half inch back of the posterior limit of the growth. 10. The growth, with its surrounding tissue, is now entirely removed with a wire snare by which the posterior attachments are severed. Much depends on the proper selection of cases. When the growth is so extensive, even though confined within the cavity of the larynx, that the larynx can not be opened without cutting into the growth, recurrence is not only possible, but probable.—*New Orleans Medical and Surgical Journal.*

Sporotrichotic Osteoperiostitis of the Upper Jaw.

D'Agata mentions the great interest awakened by the ever increasing number of manifestations and appends an instructive case of bone lesion of this origin. The patient was a youngish woman without children. Stock sound. At the age of 17 she

was in Brazil and developed severe anemia, recovering after two years with the intensive and persistent use of arsenic. Married at 24, she never became pregnant, although her husband was strong and healthy. Two years later developed an osteoperiostitis on the shin bone, thought to have been tuberculosis, and treated as such with negative results. The purulent surface which had been exposed and drained was now regarded tentatively as syphilitic, but again failed to respond to treatment. The exposed surface finally healed spontaneously, just as a fresh lesion appeared over the cheek. This increased in size until it involved the upper gum and attacked the tooth sockets. A diagnosis was made of osteoperiosititis of the upper jaw. The condition, having reached a self-limitation, remained unchanged for ten months. Prolonged study finally excluded tuberculosis, syphilis and actinomycosis. By exclusion, aided by cultural efforts, a diagnosis of sporotrichosis was made. The peculiarity of this case appeared to be its debut in the bony structures; for as a rule it attacks the latter as a result of disease of the soft parts, or the hard and soft parts are involved jointly. The rarity of the exclusive bone localization is shown by the fact that the case reported is the first known to have occurred in Italy.—*Medical Record.*

MEDICAL

A Simple Method for the Relief of Ordinary Fainting.

While attending St. Peter's Hospital in London in 1899 I was impressed with a simple procedure in daily use for the relief of this condition. It was the custom of the surgeons at that time, Mr. Reginald Harrison, Mr. E. Hurry Fenwick, Mr. J. P. Freyer and Mr. F. Swinton Edwards, to pass bougies and sounds with the patient standing. The many patients would form themselves in a long line and occasionally one of them would become faint, sometimes even before the instrument was passed. It was the custom to have a vacant chair beside the surgeon who, when he

noticed the condition of the patient, would have him seated in the chair, and the surgeon or his assistant would press the patient's head down between his (the patient's) knees, thereby lowering the head below the trunk, and by forcibly flexing the head on the chest retard the return of circulation and thus relieve the anemia of the brain. Holding down the head for a minute is sufficient. I have seen this done many times and since then I have done the same and have thereby saved myself much annoyance. If at the minute the patient shows the first sign of becoming faint the head is pressed well down between the knees, it will be unnecessary to use the horizontal decubitus. This method works beautifully in a crowded room or car.—*Journal of the American Medical Association.*

Angina Pectoris.

In the *Clinical Journal* of May 21, 1913, Saundby tells us that the preventive treatment of angina consists in the avoidance of all those things that weaken the heart, and when it is weak, to use cardiac tonics, good food, and a hygienic mode of life.

The prevention of attacks when the liability to them exists lies in avoidance of sudden exertion, excitement, overloading the stomach, alcohol, tobacco, tea, coffee and cocoa, animal purins, and chilling of the surface of the body, especially by exposure to cold winds.

The drugs that are of most service are digitalis or Nativell's digitalin or gr. 1-300 of Merck's strophanthin three times a day.

During the attacks trinitrin in 2-minim doses dissolved in water is better than chocolate tablets or nitrite of amyl. Two or three doses of trinitrin can be carried in the waistcoat pocket in separate small bottles. Its action is more prompt in solution, and its effect is more lasting than amyl nitrite. Erythrol gr. ¼ and mannitol gr. 1 have proved useful in certain cases, but Saundby gives the preference to those first named.

Where the patient is obese the diet should not only exclude purins, but be chlorine-free, no common salt being used in cooking or at table, and salt-free bread should be prescribed.

For syphilitic aortitis, biniodide of mercury gr. 1-12 and iodide of potassium 5 to 10 grains are still the best treatment. Stadler says that salvarsan has been often followed by fatal results, and he thinks that these should be treated in hospital or in nursing

Inhalations of oxygen have been sometimes found to give relief, but the gas should be warmed by passing it through hot water.—*The Therapeutic Gazette.*

Heart Disease, Use of Sugar in.

From inquiries made by the author, cardiac cases with edema, cases with anginal pains, and cases where cardiac disease is secondary to renal disease do not seem to be improved by the ingestion of sugar. In a case of general paresis in which the pulse was failing, the author did not find it to have any effect. In another case, however, he believes that the patient's life was saved by it. A woman, aged 77 years, who had pulse irregularity for some years, developed a bad heart attack, with rapid, irregular, feeble pulse, cyanosis, and attacks of paroxysmal breathing. There was no edema. Inhalation of amyl nitrite gave temporary relief, but the condition then continued for some days, the patient steadily getting worse in spite of digitalis, strychnine, dry cupping, leeching, and frequent inhalations of oxygen. One day she seemed to be dying; in the evening it appeared doubtful if she would live through the night. The author ordered some lumps of ordinary white sugar to be given in milk, and added some syrup to the patient's medicine, instructing the attendants to give her 4 ounces (120 Gm.) of sugar during the night. In the morning the patient was found very weak, but less cyanosed and with a stronger, slower pulse. Digitalis had been omitted, as well as digitalin, as these had not had any effect. Four ounces of sugar were ordered during the ensuing twelve hours, and after that it was continued in smaller quantities for some weeks. The patient made slow but study improvement. She gained strength, and at the time of writing was able to go out into the garden for a few minutes and to walk up and down stairs.—S. E. Denyer (*Lancet*, April 19, 1913).

Preliminary Report Concerning the Passage of Bacteria Through the Tonsillar Tissue as Determined by Experimental Research.

Dr. George B. Wood, Philadelphia: From a study of our experiments it seems that the following conclusions may be drawn: 1. The tonsils in the hog are more readily infected by the anthrax bacillus than any other portion of the buccal or pharyngeal mucosa. The clinical history of this disease in the hog shows that in the great majority of idiopathic cases the pharynx has been the site of invasiion, and in all of these cases of pharyngeal diseases the tonsils are the port of entry. In none of my experiments was there any involvement of the pharyngeal or buccal mucosa other than the tonsils. While the culture of anthrax was generally brought into more intimate contact with one of the tonsils, it was impossible to limit the bacilli to the tonsillar surface and they came into contact with a large part of the pharynx. In the infection an effort was made to rub the emulsion into one tonsil only and in one case the lesions were limited to one tonsil only, but this was not the tonsil on which the culture had been rubbed. 2. Anthrax bacilli penetrate through the cryptical and not the surface of the epithelium. 3. The anthrax bacillus probably gains access to the parenchyma of the tonsils by passing through the living epithelium, and having gained access through the superficial layers of the epithelium, they tended to multiply in the deeper layers and then pass into the interfollicular tissue. 4. The anthrax bacilli penetrating through the living normal epithelium cause a devitalization of the tissue, which paves the way for secondary infection from the staphylococci or other pathogenic organisms. 5. The rapidity of the invasion is influenced both by virulence of the organism and the susceptibility of the individual animal. Following the invasion the subsequent course of the disease is similar to that found in other tissues. The toxin elaborated by the bacilli causes at first an accumulation of polymorphonuclear cells, later necrosis of the tissue cells with disintegration of the nuclei. The germinating follicles show more resistance to

the disease than the interfollicular tissue. Associated with the necrotic process is an increase in the number and engorgement of the capillaries, and sometimes there is marked extravasation of the red blood cells. The anthrax bacilli accumulate in the lymph spaces and also around the blood vessel walls. In some of the sections examined the bacilli were found penetrating the blood vessel walls, and a few were found actually in the blood current.—*Texas Medical Journal.*

Pellagra Treated with Gelsemium.

The administration of gelsemium in pellagra had not been tried previous to its use in the five cases reported by Roy Blosser, 1912 (*Charlotte Medical Journal*, July, 1913). Nineteen cases are included in the present report.

While admitting that there has not been sufficient time to fully demonstrate the value of gelsemium in the cases reported, because of the exceedingly chronic nature of pellagra and its annual remissions and exacerbations, the following facts seem to indicate that the use of this drug will prove to be of great value in the treatment of pellagra: (1) Every case of pellagra so treated, excluding two patients whose condition appeared hopeless from the start, made rapid improvement in every respect. (2) Up to June 10 none of these had shown any indication of a recurrence further than some degree of malaise during the first warm weather cases in this locality have, during the same time experienced a return of the eruption and other pellagrous symptoms. (3) While some of the writer's patients are not yet cured, he feels justified from past experience in assuming that a continuance of treatment will give as good results in these as in the earlier cases treated, inasmuch as they do not appear to differ in any essential particular. (4) The remedy seems to be effective at any time of the year.

The dose of gelsemium used has generally been three drops of a fluid extract (made from the green root) three times a day after meals, but the writer has, in most cases, cut down the dose

in a few weeks to two drops, and later to one drop, continuing the latter until all pellagrous symptoms had disappeared.

The manner in which gelsemium relieves the pellagrous manifestations can only be surmised until the etiology of the disease is known. If one accepts the theory that the disease is due to some form of intoxication acting on the central nervous system, it would seem reasonable to suppose that its effect is produced by relieving this central irrigation. Thus can be explained the fact that it relieves such diverse symptoms as diarrhea, vertigo, burning sensations in the hands and feet, menorrhagia, etc. Its effect in checking diarrhea has been especially surprising, inasmuch as gelsemium has never been credited with having any stringent or sedative action on the bowels.

Gelsemium is a much less dangerous drug than is generally supposed. It seems probable that the depressing actions of the drug in the past have been due to variability in the method of manufacture or to preparations which have been allowed to evaporate or to throw down a sediment.—*Medical Review of Reviews.*

Death from Neosalvarsan.

Darier records two cases which occurred in young men aged respectively 31 and 28. The first was suffering from tertiary tuberculo-verrucose manifestations on upper extremities, but otherwise was in robust health; the other was a weakly individual in the secondary stage, with pronounced pulmonary tuberculosis and albuminuria. Both cases had already received courses of mercurial injections. The neosalvarsan was given intravenously to both patients according to Ehrlich's directions. The first case received on September 25 0.6 gramme, and on September 26 0.75 gramme, without toxic manifestations. On October 2 a third injection of 0.9 gramme was given, and on October 6, sixty-seven hours after the last injection, he died in convulsions, with a temperature of 103 deg. F. The other patient, after receiving successively on September 28, October 2 and 5, 0.45, 0.75, and 0.9

gramme of the drug, died in a similar manner on October 14, nine days after the last injection.

In a lengthy survey and discussion of these two cases and six others of a similar kind the author comes to the following important conclusions: (1) Neosalvarsan would appear to be more dangerous than salvarsan. (2) Neosalvarsan can produce very serious nervous symptoms, notably encephalomyelitis and propressive neuritis of an arsenical type. (3) Exceptionally it may cause death with symptoms of acute arsenical poisoning. (4) These catastrophes are caused apparently by retention of the drug, due to the inefficient or slow elimination, and at the present moment we have no criterion which can certainly enable us to prevent occasional accidents. It is obviously impossible to refuse administration to every case in which there would appear to be lesions of the kidney or liver. His advice is to begin treatment with small doses (a minimum of 0.2 or 0.3 gramme at first), and to increase the dosage by reasonable amounts, with minimal intervals of five or seven days, and to be sure that the preceding injection was not followed by any symptoms of intolerance; also to ascertain that the urinary excretion of arsenic is proceeding normally.—*British Medical Journal.*

Congenital Occlusion of the Post-Nasal Orifices, With Report of Case.

Dr. Charles W. Richardson, Boston: In July, 1912, a case came under my observation in which there was complete osseous obstruction of the post-nasal orifices at as early a period in the life history of the patient as any observer has noted such a condition. In search of the literature I have found only a few cases in which the obstruction was observed in infancy. While it is not possible to tabulate all the cases recorded in the literature, I judge that they do not exceed one hundred. The obstruction of the post-nasal orifice may be membranous or osseus. The former are usually found posterior to the nasal cavities in the nasopharyngeal cavity, but lie in contact with the postnasal orifices so as to completely obstruct them, while the latter are usually placed within the

chamber, within a millimeter or more from the free border of the posterior nasal orifice. To these two forms may be added congenital atresias, by which the bones entering into the formation of the postnasal orifice become united, thus more or less completely obstructing the postnasal orifices.

The child that came under my observation in July, 1912, had marked difficulty in breathing. The child struggled for air, and the face became suffused and slightly cyanosed, the condition being relieved when the child began to cry. Whenever it ceased to cry there would be a recurrence of the difficult breathing. Examination demonstrated without doubt a deformity which was a complete obstruction of the postnasal orifices. By the end of the second week the child learned to maintain mouth breathing, and also learned to feed in a short time, and has developed in a normal manner. The question is: When is the proper time to operate? The marked success with this case seemed to favor the expectant surgical policy in these cases.—*Medical News.*

Arteriosclerosis and Allied Subjects.

The three leading articles of this number are devoted to clinical and experimental arteriosclerosis and paroxysmal tachycardia. Hirsch opens with the pathogenesis and physics of arteriosclerosis. He brings the latter in direct connection with elasticity of the vessels. There is, however, much confusion as to what elasticity really is. It may be complete or incomplete. Normal arteries are completely elastic. The operation of the deforming forces tends to increase the deformity; and when these are withdrawn the *restitution ad integrum* does not at once take place. A certain amount of elasticity results as an after-effect, controlled perhaps in part by innervation. In arteries which are notably exhausted, or influenced by poisons, this secondary elasticity may constitute a grave menace. In early arteriosclerosis it is easy to note a lack of elasticity; but later on this is not at even expression of the disease, as numerous other factors may have developed—sclerosis, degeneration, calcification. Loeb considered experimental

arterial alterations on rabbits and dogs in which lactic acid was the agent employed. His work is still in progress, so that no conclusions are drawn, but the author claims that for the first time he has succeeded in producing arteriosclerosis in an animal other than man. He disputes the assertion of Boveri that arteriosclerosis may be caused in apes by injecting adrenalin. The author's rabbits did not develop the disease. In two dogs, however, in which the intima was attacked, a condition was produced very much like human arteriosclerosis. Dogs seldom develop the disease spontaneously, and even in very old dogs the findings in this respect are conflicting. Kaufmann and Popper, who consider the pathogenesis and treatment of paroyxsmal tachycardia with alternations of arrhythmia and allorhythmia, were able to demonstrate this anomaly was due to Tawara's nodes by the use of the cardiosphygmograph. When arrythmia coexisted it is due to a change in the point at which the cardiac contraction begins, and also to a certain degree of sinoauricular block. Large doses of physostigma plus strophanthus caused the cessation of the tachycardia, while the arrhythmia assumed another type (*a perpetua*). The latter type in turn is abolished by atrophin. These indications and prescriptions for their relief are worked out wholly by sphygmo- and electro-cardiagrams.—*Medical Record.*

OBSTETRICAL

Treatment of Vaginismus.

Dr. H. Rothe advises the following plan in severe cases of vaginismus: The physician impresses upon patient that after he has dilated the vaginal opening under anæsthesia, the subsequent treatment is entirely painless. To effect dilatation two fingers of the left hand are introduced into the vagina, and by the exercise of strong pressure the hymen and constrictor muscle of the vulva are gently ruptured on the left side, this being followed by introduction of a speculum of a diameter of 4 cm. On the follow-

ing day, though the wounded surface is painful, the symptoms of the vaginismus, that is, the spasm of the constrictor cunni and of the adductors of the thigh and the pelvic muscles, has disappeared. This, in itself, exerts a beneficial psychic influence. Following the suggestion of Olshausen, he introduced a pledget of cotton annointed with a 10 per cent cocain ointment into the vagina twice daily, allowing it to remain for ten minutes, and then inserts dilators of increasing size, which are left in for an hour at a time.—*International Journal of Surgery.*

Dystocia from Ventral Fixation and Amputation of the Cervix.

I wish to report a case of dystocia from ventral fixation and amputation of the cervix. A woman, 38 years of age, who had had three children. She had suffered from procidentia and was operated on in New York by ventral fixation and a fairly high amputation of the cervix. She went through her pregnancy without pain or other symptoms until labor commenced. At the time of labor there was no advance, and after being in labor for six hours the head was in the pelvis and was boring its way through the anterior wall of the uterus. The os was of pinhole size. It seemed to be a case for operation if ever a case of dystocia required such assistance, and I did a vaginal hysterotomy and with forceps delivered an eight-pound baby. The cervical canal was left of sufficient size for drainage, and the result was satisfactory.—Dr. Humpstonne in *Long Island Medical Journal.*

Repair of Perineum.

The author advocates immediate repair of the torn perineum. The procedure which has yielded most successful results in his hands has been as follows: The patient is placed on her back,

with the thighs flexed on the left abdomen and held in place with a suitable support like the Robb-Kelly strap. The vagina is cleansed of the clots and its upper part packed with sterile gauze or cotton, to make the field of operation as bloodless as possible. Then a good light is thrown into the vagina. As recommended by Robbins, the mucuous membrane and submucous membrane and submucous fascia of the opposite side of the tear with a continuous chromicized catgut suture, which begins at the upper part of the tear in the vagina and is continued on down toward the vulva. Uniting the mucous membrane and fascia with a continuous running suture, the operator tries to match the part of one side to that from which it has been torn. This restores the shape of the vagina. After the vulva has been reached the suture and needle are laid in the vagina, to be used later to unite the skin with a continuous suture. If there happens to be another tear in the vaginal sulcus or median line, as is almost always the case after the use of forceps, that tear is similarly sewed with a continuous suture, and when the vulva is reached the suture is temporarily laid aside. Then the crown sutures of silkworm gut are put in from the skin surface, slanting downward, but the rectum should not be entered, as sometimes happen, unless one takes care to feel in the rectum with a gloved hand. It is well to put the wound well forward with the sutures before tying, to see that the perineum is well cared for; they are then tied. The catgut suture that was stopped at the opening of the vulva is then picked up and with a continuous suture the denuded surfaces are brought into apposition and the suture continued down the skin. If the rectum has been torn the sphincter may be caught and brought together by a silkworm-gut suture introduced in the skin just above the rectum, passing through the muscle and out at the other side through the skin. A similar suture just above the mucous membrane of the rectum, introduced from the skin, passing around the tear in the rectum, and coming out on the skin of the opposite side, will draw the mucous membrane down like a purse-string.—G. Baughman in *Journal of the Am. Med. Asso.*

Pituitary Extract in Obstetrics.

Harrison determined experimentally that pituitary extract is of great value in cases of weakness in uterine movements after the soft parts are well dilated. Failure in these cases is rare, probably less than 1 per cent. The later in labor, but before delivery, the more striking the effect. The danger to the child and mother is very slight. As an addition to some mechinical method, e. g., the Champetier de Ribes' bag, it is of great value in bringing on premature labor or abortion. In the former case it may be sufficient in itself, but there is some risk of tetanus of the cervix, or of the uterus, especially when repeated injections are required. For delivery of the placenta its use is accompanied by the danger of tetanus uteri and retention. In post-partum hemorrhage a considerable percentage of failures may be expected.—*The Journal of the American Med. Asso.*

Quantity Versus Quality in Babies.

Professor Karl Pearson, in a lecture not long ago at the London School of Economics and Political Science, drew attention to the falling of the birthrate in England which has taken place since 1878. He showed that the process was less rapid in places like Sheffield where men were chiefly employed, whereas in places like Dewsbury, where wool was the staple industry, it was more marked. In woolen areas the average number of children in families was 1.3, in cotton areas 1.8 and in engineering areas 2.12, the interpretation being that, except in the latter case, the families, and consequently the towns, were not reproducing themselves. Emigration from the rural districts could not continue, for their birth rates, too, were falling. The character of the population was tending to become more middle-aged, and if the population was to be replaced, average families of four and five were required—a point of vital importance to the nation, for no nation of forty millions could stand one of sixty millions. That was the political aspect. The suggestions had been made that the loss

might be made good by better care of the children, but by keeping the children alive it would not be possible to get the class of mentally and physically fit children that was desired. It had to be remembered that a fall in the infant death rate is accompanied by a rise in the percentage of delicate children, and vice versa.—*Medical Review of Reviews.*

Recovery in a Case of Tetanus Neonatorum.

Wolff states that the mortality of this affection varies from 70 to 95 per cent. We know that the latter is identical with ordinary tetanus, because if matter from the navel of children who are victims of this disease is injected into experiment animals tetanus results. When we consider that the dirty treatment of the navel of the newly born at the hands of mothers and midwives has caused most of the recorded cases in the past, the simple cleanliness of the present day must have greatly lowered the incidence of tetanus. Aside from prophylaxis not much progress has been made in life saving, even under the most modern plans of treatment. The author's case is as follows: A boy aged eleven days was brought to the clinic by his mother who stated that for the past two days he had suffered the most violent convulsions. The cord had sloughed at the eighth day, the stump having been dressed by the midwife. Pus soon appeared at the navel, and trismus had developed two days later. This very brief interval caused some doubts as to diagnosis despite the absoluteness of the clinical picture. In the interest of the child no attempt was made to excise a portion of the navel for microscopic study. According to precedent the chance of finding bacilli would have been small. Hence serum was at once injected, 300 units distributed in various places. As is well known, it is difficult to supply the calorie requirements of a young infant with tetanus. The patient was narcotized with bromides and chloral until it could be fed with milk by the stomach sound; these remedies also controlling the convulsions. At times the chloral was given in the milk. This treatment was kept up until the child was able to nurse. The milk

was obtained directly from the mother's breast. The disease ran a severe course, convulsions being of the most violent type and fever correspondingly high. The calorie plan of feeding was maintained and the author does not know whether to give the most credit to the serum, chloral, or sounding feeding.—*Medical Record.*

Failure of Lactation.

H. C. Cameron notes that it may be asked why the infant should be born before the flow of milk is established, and why it should be left to the child to secure a sufficient supply by its own exertions. He believes that one may see in this a very complete and successful provision against the danger of overfeeding the child. When the child has a good appetite, sucks well, and empties the breast completely the amount of milk secreted increases with each nursing. There is here a wonderful adaptation of supply and demand. It is true to say that the child grows in strength and size because there is an increasing flow of milk; it is equally true to say that more milk is secreted because the child grows in strength and power of suction. But let some accident diminish his appetite for a few days—some slight pyrexial disorder, for example, or a trifling dyspepsia—then with diminished suction less milk is secreted, and the infant involuntarily imposes upon himself a period of partial starvation.—*Medical Record.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

PROHIBITION.

At last it seems that the State of Tennessee is to really have prohibition. Since 1909 the prohibition law has stood on the statute books but in the larger towns an uninformed visitor would never have suspected the solons of Tennessee had even debated such a question, much less have passed a law of state-wide prohibition. Since the beginning of its history Tennessee has never experienced such a period of lawlessness as during the past four years and this to a large extent has been due to the non-enforcement of the prohibition law.

We have never been in favor of prohibition, but since it is a law we deplore the fact that it has not been enforced and now, like the most fanatic anti-liquorite, we welcome the return of law, and trust that real prohibition will obtain.

We feel that sooner or later the law will be repealed and a saner law take its place. A law of segregation, local option and elimination of the stronger drinks like whiskey, absinthe and brandy. Also the elimination of the bar which is strictly an American institution; the substitution of tables and the individual check system which would help eliminate the treating custom which has a great deal to do with excessive drinking.

We feel that however stringent a prohibition law may be, it can not stop whiskey drinking but will force many who now

drink only beer to fall back on whiskey, because it can be smuggled in so much easier.

Beer is more a food and tonic than an intoxicant and comparatively few drunkards use this beverage. Any pathologist will tell you that it takes enormous daily quantities of beer to produce pathological changes in the vital organs of the body. The cost of wine makes its use prohibitive for many and with a higher tax to make its cost still greater few could indulge in this.

Prohibition has made great strides during the past thirty years but not through the prohibition party so much as through certain church organizations throughout the country. Elimination of stimulants would have been a much easier task had the work been more systematically mapped out. For instance, we have state-wide prohibition here in Tennessee and comparatively little attention is attracted by the flagrant sale of morphine and cocaine to say nothing of the use of heroin, which is becoming very popular.

Logically it would be wise to make the sale of narcotic drugs like opiates and cocaine a crime punishable by imprisonment unless such drugs were prescribed by a reputable physician. After obtaining and *enforcing* a law against narcotic drugs, absinthe, brandy, whiskey could have been prohibited, which would still have left wines and beers. If trial showed wines and beers alone cause the same liquor problems as when the stronger intoxicants were used, public opinion would have demanded a prohibition law against their sale also.

To ask too much at one time is a procedure which has never borne fruits in private or public life. And for that reason, while we hope that the prohibition law will really prohibit, we feel that it will do so only temporarily and that when beer can once again be bought and drank in a saloon many who formerly only took beer will call for whiskey, having acquired a taste for that habit forming drug while beer could not be purchased.

W. T. B.

Art in Anatomy.—Medicine.

Many medical men will well remember at various times receiving a copy of Rembrandt's Celebrated School of Anatomy. It was the writer's good fortune recently to see the original of this in the museum of The Hague, Holland, while there to see Carnegie open his new Peace Palace. This wonderful painting was done by Rembrandt in 1632 for the Amsterdam Guild of Surgeons, to hang on the walls of their synkamer or dissecting room. This painting remained with the surgeons guild at Amsterdam until 1829, when it was purchased by William II for 32,000 florins. The strong point in this picture is its protraits. This picture has been described as the truest and most lifelike representation of the working of intellect ever put on canvas. Rembrandt always has a central figure and in this picture it is the celebrated anatomist, Rembrandt's friend, Prof. Nicholas Tulp. Around the professor is a group of seven men, not young students, but the learned surgeons of Amsterdam. The corpse which lays before the Professor most faithfully presents the peculiar hue of the dead body, doubtless it is as well, as the portraits were painted from nature. We might say the portraits were painted from life and the corpse was painted from death. This picture always had a crowd before it in silent and respectful admiration. Rembrandt has other anatomical pictures at Amsterdam, chief of which is the Anatomical Lecture, showing a prosection of the brain.

E. S. McK.

The British Association for the Advancement of Science.

The British Association for the Advancement of Science, held its Annual meeting at Birmingham, England, September 10-17, 1913. The writer being a member made haste to be there, as he was in England after the International Medical Congress. The meeting was a success, numerically, scientifically and socially. There were present 3536 members. These came mostly from

England, yet about all the colonies were represented, a few from America and some visitors from the continental nations. The degree of LL.D. was conferred on Mme Curie, of Paris, R. W. Wood, Baltimore; Savante Arrhenius, Stockholm; H. A. Lorentz, Leydon, and Keibel, of Freiburg. Mme Curie, the discoverer of radium, was described by Sir Oliver Lodge, principal of the University and president of the association, in conferring the degree, as "the greatest woman scientist of all time." She received the most applause of all and seemed quite a favorite with the audience. Of the twelve sections into which the association was divided, those of chemistry, botany and physiology were of interest to the medical man with reference to his profession. The writer was present at the meeting of the British Association at Winnipeg four years ago and well remembers the valuable reports and discussions of the subject of "Anæsthesia" at that time and place. These reports and discussions with exhaustive investigations have been going on ever since, and the report this year was none the less valuable than former years. The sections worked forenoons and played afternoons and evenings. It was rarely that papers were read in the afternoon. There were some popular lectures and special addresses and the president's address, made in the evening, but not the regular section work. The British Association knows how to enjoy itself as well as to work. The meeting will be held in Australia next year. *E. S. McK.*

Messrs Rebman, Publishers, take pleasure in informing the profession that the International Medical Congress, held during the first week in August, 1913, has awarded to them the Gold Medal for the best medical publications.—New York City, August 28, 1913; 141-145 W. 36th St., Herald Square Building.

OBITUARY.

We note the death at Franklin, Tenn., of Dr. Samuel Henderson, September 15, one of the best known practitioners of medicine in that community. He died after a brief illness in the sixty-second year of his age. Dr. Henderson was much beloved by his people and his death will be widely mourned.

Dr. Jas. E. Cage, of Carmel, Tenn., died at his home from the infirmities of old age at the age of 76 years. Dr. Cage was a Confederate soldier, serving throughout the war, and after the war he took up the practice of medicine and for nearly half a century was one of the leading practitioners in the section in which he lived. His death was peculiarly sad as it took place at the time for which a family reunion had been appointed.

THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Preliminary Program and Circular of Information of the Thirty-ninth Annual Meeting at New Orleans, La.

Secretary's Office, 705 South Third Street.

Louisville, Ky., October, 1913.

The Mississippi Valley Medical Association meeting will be held at the Hotel Grunewald, New Orleans, La., Thursday, Friday and Saturday, October 23, 24, 25, 1913, under the Presidency of Dr. Albert E. Sterne of Indianapolis, Ind.

The arrangement for the meeting are in charge of a committee headed by Dr. W. W. Butterworth. Information in regard to accommodations should be addressed to Dr. M. A. Shlenker, New Orleans, Chairman of the Hotel Committee.

The meetings of the Association have always been made more pleasant because of the number of ladies present. It is hoped a large number will attend this year. The local committee promise much of interest for them.

RAILROAD RATES.

Advantage can be taken for this meeting of the regular round-trip home-seekers' rates to southern territory which are practically one fare for the round trip. These tickets are on sale *only on*

Tuesday, October 21. A saving can be made in the tickets if it is not convenient to leave on the 21st, by purchasing a round-trip winter tourist ticket.

HEADQUARTERS.

The Hotel Grunewald has been selected as headquarters, and all general meetings and both medical and surgical sections will be held on the top floor. The commercial exhibits will also be on this floor. Members and visitors are urged to make reservation of rooms as early as possible.

PANAMA TRIP.

A contract has been entered into with the Travel Service Bureau of St. Louis for the trip to Panama, and details of the cost and extent of the trip will be sent on request.

SESSION IN DETAIL.

The Association will be called to order by the Chairman of the Committee on Arrangements, Dr. W. W. Butterworth, at 10 a.m., October 23, and the opening exercises held. At the conclusion of these the general session will adjourn to the two sections, meeting in different halls.

The first evening in the main hall will be heard the address of the President, Dr. Sterne, and the orations in medicine and surgery. Dr. Henry B. Favill of Chicago, will deliver the oration in medicine and Dr. Wm. L. Rodman of Philadelphia, the address in surgery. Dr. Jno. A. Witherspoon of Nashville, will deliver the memorial address.

The symposia and the papers in general will be replete with interest.

Details of the forms of entertainment have not been completed, but will be announced in the final program.

SCIENTIFIC PROGRAM.

NOTE—*All papers read at the meeting in full, in abstract, or by title are the property of the Association, and can not be published except in the official manner, without permission.*

The following is a list of papers completed to August 15:

SYMPOSIUM ON PEDIATRICS.

Abt, I. A., Chicago Ill.—Classification of Gastro-Intestinal Diseases of Infancy.

Neff, Frank C., Kansas City, Mo.—The Feeding of the Sick Infant.

Richter, H. M., Chicago, Ill.—Pyloric Stenosis in Infancy: an analysis of twenty cases personally operated upon.

Sedwick, Julius H., Minneapolis, Minn.—Researches in the Chemistry and Metabolism of Digestion.

Snyder, J. Ross, Birmingham, Ala.—Some Points in the Treatment of Acute Ileo-Colitis.

Discussion opened by W. W. Butterworth, I. R. DuBuys, New Orleans, La.

SYMPOSIUM ON THE KIDNEY.

Boggess, W. F., Louisville, Ky.—Medical Treatment of Bright's Disease.

Fisher, Martin H., Cincinnati, Ohio—The Nature, Cause and Principles of Treatment in Nephritis.

Dodd, Walter, Boston—X-ray in Kidney Lesions.

Eisendrath, Daniel N., Chicago, Ill.—The Pathological and Clinical Aspects of Renal Infection.

Fowler, O. S., Denver, Colo.—

Squier, J. Bentley, New York, N. Y.—

Scheick, Henry J., St. Louis, Mo.—Some Phases of Kidney Surgery.

Wishard, W. N., Indianapolis, Ind.—

Discussion opened by John R. Caulk, St. Louis, Mo.

SYMPOSIUM ON SOCIAL HYGIENE.

Norbury, Frank P., Springfield, Ill.—Social Factors in the Prevention of Insanity.

Trawick, John D., Louisville, Ky.—Heredity and Eugenics.

Yarros, R. S., Chicago, Ill.—Various Aspects of the Social Hygiene Movement.

SYMPOSIUM—GENERAL SESSION.

Vaughan, Victor C., Ann Arbor, Mich.—The Relation of Anaphylaxis to Immunity and Disease.

Weil, Richard, New York, N. Y.—The Result of the Study of Various Theories of the Anaphylactic.

Loeb, Leo, St. Louis, Mo.—Some Recent Results of Cancer Investigation.

Watkinns, T. J., Chicago, Ill.—Ovarian Secretions.

Discussion opened by G. W. McCaskey, Ft. Wayne, Ind.

SYMPOSIUM ON THE CIRCULATION AND BLOOD PRESSURE.

Yates, J. L., Milwaukee, Wis.—Surgical Aspect.

Marvin, J. B., Louisville, Ky.—Disorders of the Peripheral Circulation.

Stone, Willard J., Toledo, Ohio—The Clinical Significance of Diastolic Pressure Variations with Especial Reference to Hypertension and Cardiac Over-load.

Williamson, Charles Spencer, Chicago, Ill. — The Functional Testing of the Cardiac Power.

Butler, Geo. F., Kramer, Ind.—Blood Pressure and Cardiovascular—Disturbances.

Barclay, W. F., Pittsburg, Pa.—Rheumatism, Its Etiology, Pathology and Treatment in a Study of over Three Hundred Recorded Cases.

Babcock, Robert H., Chicago, Ill.—Endocarditis with specimen.

Barrett, Channing W., Chicago, Ill. — Some New Points in Round Ligament Surgery. With Lantern Slide Illustration.

Benjamin, A. E., Minneapolis, Minn.—Thyroid Surgery with Special Reference to the Technic.

Bierring, Walter L., Des Moines, Ia.—Embolism and Thrombosis; A series of unusual circulatory accidents occurring in acute infections.

Burr, C. B., Flint, Mich.—On Symbolism and Word Obsession.

Byrd, Hiram, Jacksonville, Fla.—Tuberculosis in the Mississippi Valley.

Eastman, Joseph Rilus, Indianapolis, Ind.—Jackson's Membrane in Children.

Crile, George W., Cleveland, Ohio—

Dock, George, St. Louis, Mo.—

Elliott, Arthur R., Chicago, Ill.

Emerson, Charles B., Indianapolis, Ind.—Diabetes.

Eve, Duncan, Nashville, Tenn.—Treatment of Recent Fractures of the Femur.

Frank, Louis, Louisville, Ky.—Recognition of Renal Calculus.

Frazier, Charles H., Philadelphia, Pa.—

Glenn, Eugene B., Asheville, N. C.—

Haggard, W. D., Nashville, Tenn.—Is it Ulcer of the Stomach or Gallstone?

Haines, W. D., Cincinnati, Ohio—Pancreatitis as a Factor in Digestive Disorders.

Hanes, Granville S., Louisville, Ky.—Urgent Need for a More Thorough Study of Disease Affecting the Region of the Rectum.

Jackson, Jabez N., Kansas City, Mo.—

Johnson, J. H., Coffeyville, Kas.—The Medical Treatment of Goiter.

McRae, Floyd W., Atlanta, Ga.—The Acute Surgical Abdomen—Abuse of Purgatives.

Minor, C. L., Asheville, N. C.—The Use and Abuse of Exercise and Rest in the Treatment of Pulmonary Tuberculosis.

Ochsner, A. J., Chicago, Ill.

Plummer, H. S., Rochester, Minn.—Classification and Diagnosis of Goiter.

Pottenger, F. M., Monrovia, Cal.—The Possibility of Differentiating Between Active Quiescent and Healed Tuberculosis by the Character of the Reaction to the Cutaneous Tuberculin Test.

Ruth, C. E., Des Moines, Ia.—Extrophy of the Bladder, with Case Reports.

Schwab, Sidney I., St. Louis, Mo.—

Smithies, Frank, Rochester, Minn.—Test-meal Findings in 700 Cases of Cancer of the Stomach.

Sloan, H. G., Cleveland, Ohio—The Resuscitating Influence of Adrenalin and Normal Saline Solution.

Weissenberg, Theodore, Philadelphia, Pa.

Windell, J. T., Louisville, Ky.—Anent the Socalled "Whitie-slave" Law.

The following will lead in discussion of papers to be announced later:

Leathers, W. S., University, Miss.

Genella, L. J., New Orleans, La.

Fuller, William, Chicago, Ill.

Dunlap, Elbert, Dallas, Texas.

Ward, J. P., Vevay, Ind.

Murphy, John B., Chicago, Ill.

Reviews and Book Notices

Malaria, Etiology, Pathology, Diagnosis, Prophylaxis and Treatment—By Graham E. Hendon, M.D., Member American Medical Association, Southern Medical Association, American Society of Tropical Medicine, Medical Reserve Corps, United States Army (Non-active List). With an Introduction by Charles C. Bass, M.D., Professor of Experimental Medicine, Medical Department Tulane University, New Orleans; 27 illustrations. St. Louis. C. V. Mosby Co. 1913.

This admirable brochure should be very acceptable to the general practitioner as it presents a very important subject in a thoroughly practical manner. When one reflects that the successful issue of the Panama Canal, the greatest engineering project of modern times, was due in great measure to scientific sanitation looking to the eradication of malarial diseases, and the prevention and cure of that and other tropical diseases, he can readily appreciate the value of a work that presents the subject in all its phases in the most practical and scientific manner. We can conscientiously commend the book to our readers as a most valuable handbook in the study of malarial diseases

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The Surgical Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. Vol. II, No. 4 (August, 1913). Octavo of 206 pages, 49 illustrations. Philadelphia and London: W. B. Saunders Co., 1913. Published Bi-Monthly. Price per year: Paper, $8.00; Cloth, $12.00. W. B. Saunders Co., Philadelphia and London.

Our thanks are due the enterprising publishers for a copy of the August number of this excellent publication. As with former numbers this volume abounds with interesting lectures. The opening article is one by Philip H. Kreuscher, M.D., of Dr. Murphy's clinic, on "Some Observations on Vaccine and Serum Therapy from Dr. Murphy's Clinic," which gives a reader many valuable points in the study of this progressive branch of modern therapeutics. A feature of note in this number is ten skiagrams of the blood supply in and around the joints, a most excellent method of demonstrating the blood supply of joints and collateral

circulation. The other papers of this number are one and all valuable as so many steps in the development and advance of surgical procedures. The thanks of the profession are due the distinguished surgeon and the up-to-date publishers for having presented a serial of such exceeding value to all interested in scientific surgery.

The Doctor in Court—By Edwin Valentine Mitchell, LL.B., of the Massachusetts Bar. New York. Rebman Co., Herald Square Building.

This will prove to be a useful little book for physicians as occasionally it is his misfortune to be called as a witness in the various courts of the land. It gives "briefly and in high relief the general principles of law relating to the medical profession and the reasons for those principles." To give the reader an idea of the scope of the book, we give the contents: (I) Professional Evidence. (II) The Contract of the Profession. (II) Civil Responsibility of the Profession. (IV) Remuneration. (V) Confidential Communications. (VI) The Criminal Responsibility of the Profession. (VII) Qualifications. Table of Contents. General Index.

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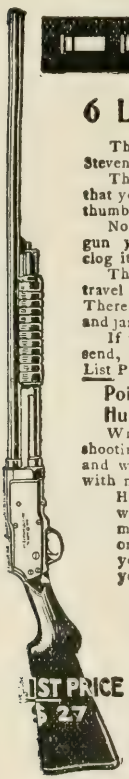

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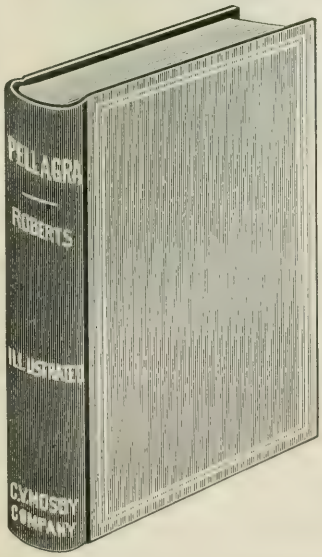

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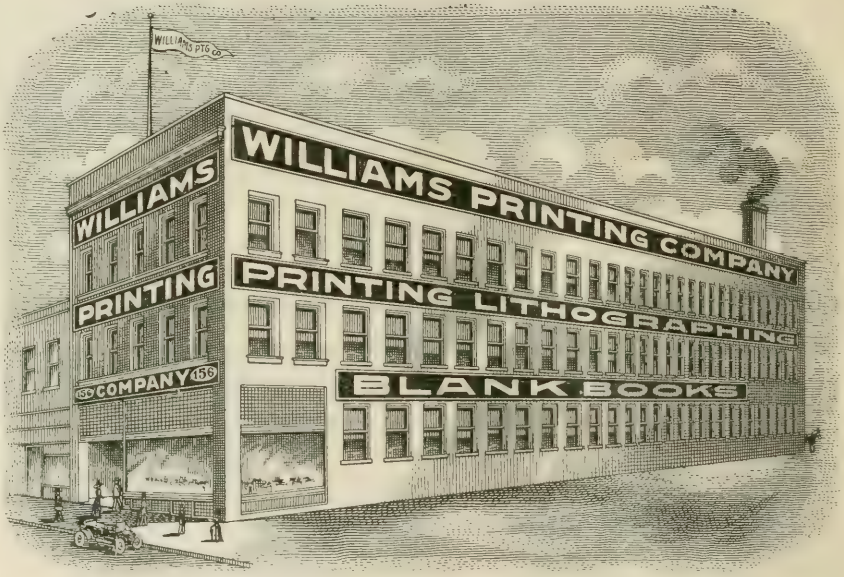

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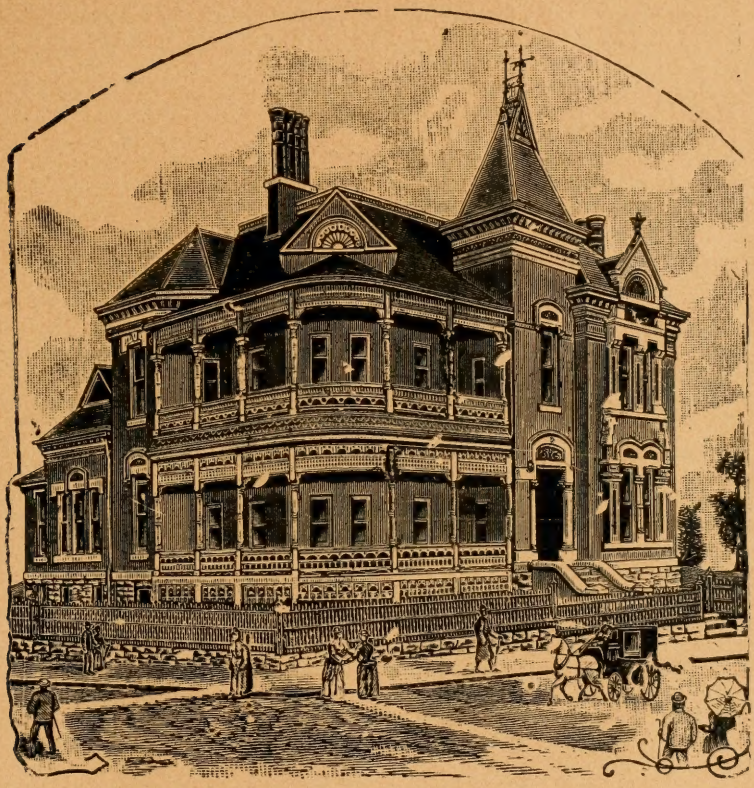

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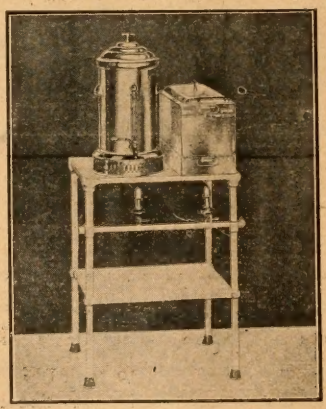

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